Division of Medical Assistance **Clinical Coverage Policy No.:**
Telemedicine and Telepsychiatry **Original Effective Date: August 1, 1999**
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1.0 Description of the Service

1.1 Telemedicine

Telemedicine is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability and/or expertise to provide and support health care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telemedicine.

1.2 Telepsychiatry

Telepsychiatry is the use of two-way real time-interactive audio and video between places of lesser and greater psychiatric expertise to provide and support psychiatric care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telepsychiatry.

1.3 Service Sites

The originating site (formally known as the spoke site) is the facility in which the recipient is located. The distant site (formally known as the hub site) is the facility from which the provider `provides the telemedicine or telepsychiatric service. All service sites must be Medicaid enrolled providers.

1.4 Providers

The referring provider is the provider who has evaluated the recipient, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of diagnosis and treatment.

The consulting provider is the provider who evaluates the recipient via telemedicine/telepsychiatry mode of delivery upon the recommendation of the referring provider. Treatment is initiated as needed.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.****** A screening examination includes any evaluation by a physician or other licensed clinician. EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, or experimental/investigational.

Service limitations on scope, amount, duration, and/or frequency and other specific criteria described in clinical coverage policies may be exceeded or may not apply provided documentation shows that the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.

****EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT Provider Page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Service Is Covered

Important Note: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination **(subject to prior approval requirements, if applicable)**. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy or visit the DMA Web sites specified below.

Basic Medicaid Billing Guide: http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT Provider Page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

Medicaid covers telemedicine and telepsychiatry when the service is medically necessary and:

1. the service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs; and
2. the service can be safely furnished, and no equally effective and more conservative or less costly treatment is readily accessible.

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4.0 When the Service Is Not Covered

Important Note: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination **(subject to prior approval requirements, if applicable)**. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy or visit the DMA Web sites specified below.

Basic Medicaid Billing Guide: http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT Provider Page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

4.1 General Criteria

Telemedicine and telepsychiatry are not covered when the physician does not have a full and unrestricted license to practice medicine in North Carolina, as required by Article 1, Chapter 90, of the General Statutes or when

1. the recipient does not meet the eligibility requirements listed in **Section 2.0.**
2. the recipient does not meet the medical necessity criteria listed in **Section 3.0.**
3. the service duplicates another provider's service.
4. the service is experimental, investigational, or part of a clinical trial.
5. the patient is located in a jail, detention center, or prison.
6. the consulting provider is not a NC Medicaid in-state enrolled provider

4.2 Specific Criteria

1. Facility fees for the distant site are not covered.
2. The following interactions do not constitute reimbursable telemedicine or telepsychiatry and will not be reimbursed:
   a. a telephone conversation
   b. video cell phone interaction
   c. e-mail message
   d. facsimile transmission between a health care provider and a recipient
   e. "store and forward" recipient visits and consultations, which are transmitted after the recipient is no longer available

5.0 Requirements for and Limitations on Coverage

Important Note: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination **(subject to prior approval requirements, if applicable)**. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy or visit the DMA Web sites specified below.

Basic Medicaid Billing Guide: http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT Provider Page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

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5.1 General Criteria

1. The recipient must be present.
2. The telecommunications must permit encrypted real-time interactive audio and video communication with the consulting provider.
3. The referring provider participates in the service as appropriate to meet the medical needs of the recipient. For more information on this service see 5.2-c.
4. The provider at the remote site must obtain prior approval for services when these medical or psychiatric services require prior approval, based on service type or diagnosis.

5.2 Limitations

1. Up to three different consulting providers may be reimbursed for a separately identifiable telemedicine or telepsychiatry service provided to a recipient per date of service.
2. Only one facility fee is allowed per date of service.
3. There is no reimbursement to the referring provider at the originating site on the same date of service unless the referring provider is billing for a separately identifiable billable service. Medical records must document that all of the components of the service being billed were provided to the recipient.

5.3 Prior Approval

Prior approval is required when the service is rendered outside a 40-mile radius of North Carolina's borders (10A NCAC 220.0019).

6.0 Providers Eligible to Bill for the Service

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for telemedicine and telepsychiatry when the service is within the scope of their practice.

6.1 Telemedicine Professional Services

The following providers enrolled in the N.C. Medicaid program who provide this service may bill Medicaid:

1. Physicians
2. Nurse practitioners
3. Nurse midwives

6.2 Telepsychiatry Professional Services

The following providers enrolled in the N.C. Medicaid program who provide this service may bill Medicaid:

1. Physicians
2. Advanced practice psychiatric nurse practitioners
3. Advanced practice psychiatric clinical nurse specialists
4. Licensed psychologists (doctorate level)

5. Licensed clinical social workers (LCSW)
6. Community diagnostic assessment agencies

6.3 Facility Fees

The following providers may bill for a facility fee when their office or facility is the site at which the recipient is located when the service is provided:

1. Physicians
2. Nurse practitioners
3. Nurse midwives
4. Advanced practice psychiatric nurse practitioners
5. Advanced practice psychiatric clinical nurse specialists
6. Licensed psychologists (doctorate level)
7. Licensed clinical social workers (LCSW)
8. Hospitals (inpatient or outpatient)
9. Federally qualified health centers
10. Rural health clinics
11. Local health departments
12. Local Management Entities

Refer to Attachment A, Section C for a list of billable codes.

7.0 Additional Requirements

7.1 Medical Record Documentation

Medical records documenting the telemedicine or telepsychiatry services that were provided must be maintained by the referring and the consulting provider.

Providers must follow Medicaid's guidelines on medical record documentation as published in the ***Basic Medicaid Billing Guide*** on DMA's Web site at http://ncdhhs.gov/dma/medbillcaguide.htm.

7.2 Best Practice Guidelines for Documentation of Mental Health and Substance Abuse Services

Medical records of telepsychiatric interventions are to be maintained as with psychiatric interventions in general. Telepsychiatry providers must also follow Medicaid's best practice guidelines for medical record documentation as published in **Attachment B** of **Clinical Coverage Policy #8A, *Enhanced Mental Health and Substance Abuse Services*** on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

7.3 Designating a Primary Provider

The medical record must document the provider who is designated as having primary responsibility for management and coordination of each major element of care.

7.4 Provision of Care

Evaluation and/or treatment must be performed in an environment where there is a reasonable expectation of absence of intrusion by individuals not involved in the patient's direct care. Providers may not require the use of telemedicine as a condition of treating the recipient. Providers should develop their own methods of informed consent verifying that the recipient agrees to receive services via telemedicine.

8.0 Policy Implementation/Revision Information

Original Effective Date: August 1, 1999

Revision Information:

Date	Section Revised	Change

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Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

1. CMS-1500 Claim Form

Physicians, nurse practitioners, nurse midwives, licensed psychologists, licensed clinical social workers, and certified clinical nurse specialists enrolled in the N.C. Medicaid program bill services on the CMS-1500 claim form.

2. UB-92 Claim Form

Hospital providers bill services on the UB-92 claim form.

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

1. CPT Codes

The following CPT procedure codes can be billed by the consulting provider for professional services:

- 90801
- 90804 through 90809
- 90862
- 99201 through 99205
- 99211 through 99215
- 99241 through 99245
- 99251 through 99255

Advanced practice psychiatric clinical nurse specialists, licensed psychologists, and licensed clinical social workers as consulting providers may bill only the following codes:

- 90801
- 90804
- 90806
- 90808

2. HCPCS Codes

The following HCPCS code can be billed for the facility fee by the originating site (the site at which the recipient is located): Q3014. Refer to **Section 6.3** for list of providers.

HCPCS code T1023 can be billed only by diagnostic assessment agencies for screening/evaluation to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter (1 unit =1 event). T1023 (1 unit) is billed for the date that the total assessment is completed by the agency that employs the providers of service.

3. Revenue Codes

When the originating site is a hospital, the originating site facility fee must be billed with RC780 and Q3014.

D. Modifiers

Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via "Interactive Telecommunication." Other modifiers must be appended to the CPT codes, as appropriate.

E. Place of Service

These services may be provided in inpatient, outpatient, and office/clinic settings.

F. Co-payments

Telemedicine and telepsychiatry services are subject to co-payment requirements.

G. Reimbursement

1. When the GT modifier is appended to a code billed for professional services, the service is paid at 100% of the allowed amount of the fee schedule.
2. For hospitals, this is a covered service for both inpatient and outpatient and is part of the normal hospital reimbursement methodology.
3. Reimbursement for these services is subject to the same restrictions as face-to-face contacts (e.g., place of service, allowable providers, multiple service limitations, prior authorization).